SECTION 14
FREQUENTLY ASKED QUESTIONS

INPATIENT HOSPITAL

What date is considered the date of admission for an inpatient hospital stay?
MO HealthNet follows Medicare policy on the date of admission. Medicare policy is: "A patient of a hospital is considered an inpatient upon issuance of written doctor orders to that effect".

How does a provider submit an inpatient claim that requires a two-page claim for all the services?
If at all possible, the provider should list all the services on a single claim form. If this is not possible, the provider may bill the services on two claim forms. In field 80 on the first page of the claim, put “page 1 of 2”. In field 80 of the second page, put “page 2 of 2”. Staple the claims together prior to submission.

Does a provider have to submit a claim to Medicare for a patient who has exhausted his/her Medicare inpatient benefits and get a denial from Medicare before filing a claim to MO HealthNet?
Yes. MO HealthNet requires that a claim be filed to Medicare first before filing a claim to MO HealthNet. Once the denial has been received, a paper claim can be filed to MO HealthNet and a copy of the Medicare denial or exhausted benefit letter attached to it. The claim can be filed also using the X12 837 institutional claims transaction or the direct data entry inpatient or outpatient claim through the MO HealthNet Internet billing Web site, emomed.com. The range of dates on the claim to be filed to MO HealthNet must fall within the range of dates on the claim filed to Medicare. The denial code description should be visible on the Medicare denial or entered in the appropriate field(s) on the electronic claim form.

Are hospitals required to keep paper copies of attachments related to physicians’ inpatient services, e.g. Second Surgical Opinion Form, Sterilization Consent form, etc.?
Yes. The hospital must maintain a paper copy of these forms in the patient’s permanent file.

Is the inpatient hospital per diem rate based on the date of admission or the date of service when there is a rate change?
The per diem rate is based on the date of admission.

A hospital receives certification for a patient admission and admits the patient. Later in the admission day, the patient has to be transferred to another facility which also needs certification. How is this processed and how would the services be billed?
The MO HealthNet *Hospital Provider Manual*, Section 13.30.B - DAY OF DISCHARGE, DEATH, OR TRANSFER states: "MO HealthNet reimburses a facility for the day of admission. MO HealthNet does not cover the day of discharge, death or transfer **unless it also is the day of admission and then it is reimbursable**. The costs for the day of discharge, death or transfer cannot be billed to the recipient."

In the example above, both facilities must obtain certification from Health Care Excel (HCE). Whichever facility submits a properly completed claim to MO HealthNet first should receive reimbursement. The facility that submits a claim to MO HealthNet second will have its claim denied as a duplicate unless a completed *Certificate of Medical Necessity* (CMN) is submitted with the claim to justify the care on the same date of service. It is advisable, however, for both facilities to submit a completed *Certificate of Medical Necessity* with their claims to avoid a duplicate service denial. The *Certificate of Medical Necessity* can be submitted electronically through the MO HealthNet Internet billing Web site, emomed.com, as an attachment to the electronic claim by clicking on the "Add Header Medical Necessity" link at the bottom of the claim page.

A hospital wants a pre-certification for a pregnant woman for a medical condition unrelated to the pregnancy, e.g. mental health services. Should a pregnancy diagnosis code be reported?
HCE does not review most pre-certifications if the admitting or primary diagnosis code is related to pregnancy. Therefore, a diagnosis code relating to pregnancy should **not** be used as the admitting/primary diagnosis code. If the hospital stay is not related to pregnancy, it must be clear that the pregnancy is incidental to the admitting/primary diagnosis.

Are there special documentation requirements for billing for inpatient missed abortions/miscarriage services?
MO HealthNet does **not** cover elective abortion services.

Any claim with a diagnosis of miscarriage, or missed or spontaneous abortion, diagnosis codes 632, 634.00-634.92, 635.00-635.92, 636-636.92 and 639-639.9, must be submitted on a paper UB-04 claim form with all appropriate documentation attached. The documentation must include the operative report, an ultrasound, the pathology report, the admit and discharge summary, etc. to show that this was not an elective abortion. If no ultrasound was performed, the reason for not performing it must be clearly documented in the patient's medical record.

The above information is required also when submitting a claim with ICD-9 surgical code 69.93.

ICD-9 surgical codes 69.01, 69.51, 69.93, 69.99, 74.91, 75.99, and 96.49 also require a completed *Certification of Medical Necessity for Abortion* form in addition to the previously noted documents.

OUTPATIENT HOSPITAL

Is a pre-certification required from Health Care Excel (HCE) for outpatient services and/or surgical procedures?
No, a pre-certification from HCE is not required for outpatient services and/or surgeries.

If a hospital has an outpatient claim that requires the submission of a second page for services provided on the same date, should two separate claims be filed or can a two-page claim be submitted with the total appearing on the second page?
In this instance, the provider should submit two separate claims and total each individual claim page.

When billing for an outpatient facility charge, should a CPT/HCPCS code be entered in addition to the outpatient facility revenue code?
No. Enter only the appropriate outpatient facility revenue code. Do **not** list a CPT or HCPCS code along with the facility revenue code.

Can a provider bill for two emergency room visits on the same day for the same patient?
If the second ER visit is essentially for the same reason as the first, the hospital cannot bill for it. If the second visit is for a different reason, the hospital can bill for the visit. The two visits must be billed on the same paper claim and the ER notes for each visit attached to it.

If the patient has two ER visits on the same day at two different hospitals, whichever hospital submits a claim first will be paid. The provider that bills second will have its claim denied and will have to refile a paper claim with the ER notes attached to it.

How are emergency room services billed that continue from the initial day into the following day?
For any ER service that continues past midnight, including the facility charge, use the date the patient was initially seen in the ER as the date of service.

How are observation services billed that continue from the initial day into the following day?
For any observation room services that continue past midnight, including the facility charge, use the date the patient initially was put in observation as the date of service. Bill only one observation room facility charge for the entire stay. Do **not** bill one for the first day and a separate one for the second day.

Can a hospital bill for multiple dates of service on the same claim for either emergency room services or therapy services and use the AJ condition code to exempt the patient from the $3.00 cost sharing amount for each date of service reported on the claim?
No. Only one date of service can be reported on an outpatient hospital claim on which the AJ condition code is reported. The AJ condition code is used on the outpatient hospital claim to exempt the patient from the $3.00 cost sharing for emergency room services or outpatient therapy services (physical therapy, chemotherapy, radiation therapy, psychology/counseling and renal dialysis).

A MO HealthNet patient presents to the hospital emergency department for non-emergent care. Eligibility is checked and it is determined the patient is administratively locked-in to a provider. The ER department tries to contact the designated lock-in provider who either is not available or will not authorize the services through the PI-118 lock-in form. Since the ER department cannot get a referral from the lock-in provider, can these services be billed to the patient or does the hospital have to write them off?
The patient can be billed for the care. Patients who have been administratively locked-in to a designated provider know this and know who their lock-in provider is. Further, they know that if they try to obtain non-emergent services from another provider, the patient can be held responsible for the costs of the service if the treating provider is unable to obtain a referral from the lock-in provider.

How are claims for pharmaceuticals used in the outpatient or emergency room setting filed?

Effective for dates of service February 1, 2008 and after, hospitals no longer can bill general pharmaceuticals used in the outpatient or emergency room hospital setting on the paper UB-04 claim form. Claims for pharmaceutical items must be billed electronically.

Providers submitting claims for injections, drugs or pharmaceutical items (salves, creams, etc.) on an electronic Professional or Institutional ASC X12N 837 Health Care claim transaction or manually entering a claim into MO HealthNet's billing Web site, www.emomed.com, in addition to the NDC, the claim must include the HCPCS or CPT procedure code along with the appropriate corresponding revenue code that best represents the NDC being billed. Claims submitted with J-codes only, without a corresponding NDC, will be denied. A field has been added to the emomed.com UB-04 outpatient claim form to allow providers to list the NDC, the metric quantity and the prescription number.

The system will automatically generate a separate claim for the NDC to process as a Pharmacy claim and will appear as a separate claim on the Remittance Advice. The corresponding HCPCS or CPT procedure code will be dropped from the claim unless an NDC is not provided, then it will remain to report the denied line.

NDCs may be billed with the appropriate HCPCS or CPT procedure code for the medication or item being administered or dispensed. This includes but is not limited to C-codes, G-codes, J-codes, Q-codes, S-codes and non-VFC vaccination codes.

NDCs without corresponding J-codes **cannot** be billed under the following J-codes.

J-3490 – unclassified drug
J-7599 – immunosuppressive, not otherwise classified
J-8499 – prescription drug, oral, non-chemotherapeutic, NOS
J-8999 – oral prescription, chemotherapeutic, NOS

Providers also have the option to submit a separate claim to report only the drug information by using the Pharmacy claim option at the MO HealthNet billing Web site. This is the same option currently used by physician clinics when billing for injectables dispensed in their clinic. The J-code is not to be submitted when using this option.

For more detailed filing instructions, please see the "Help" option at the bottom of each claim form on the MO HealthNet Billing Web site or the X12N Version 4010A1 Companion Guide for the electronic 837 claims.

Sometimes the hospital gives the patient a two day supply of a pharmaceutical item. How are such items to be billed?

MO HealthNet policy allows hospitals to send up to a two day supply of medications home with a participant due to lack of pharmacy availability at night or on weekends. This take-home medication must be billed with two separate dates of service. For example: A two day supply of take-home medication(s) is given to the participant on Friday, March 14, 2008. The claim will reflect a one day's supply of medication(s) with the date of service March 14, 2008. The second day's supply will have the date of service March 15, 2008. Line details with a "From" and "Through" date of service totaling more than one day's supply will be denied.

Are NDCs required for Medicare crossover claims?

Yes. Medicare/MO HealthNet Crossover claims require the NDC for all drug charges with coinsurance and/or deductible amounts to be considered for payment. Editing will be applied to check for validity of the NDC and Metric/Decimal Quantity combinations. However, the drug information will remain on the crossover claim in the form of the HCPCS or CPT procedure code submitted and will not be processed separately.

The line detail of a crossover claim submitted via the Professional or Institutional ASC X12N 837 Health Care claim transaction is capable of holding up to 25 different NDC and Metric/Decimal Quantity combinations. If a claim line detail is submitted with multiple NDC and Metric/Decimal Quantity combinations, the coinsurance and/or deductible amount(s) will be considered for payment if at least one combination is valid. If none of the NDC and Metric/Decimal Quantity combinations are valid, the line will deny.

A prescription number is now required for the drug claims. How does the hospital determine this number?

The prescription number is a required field and must be a unique sequential identification number. The patient account number may be used but an additional unique identifying numeric character must be added to this patient account number to make it unique for each occurrence of dispensed or administered drugs. The prescription number is used to sort claims submitted electronically on the remittance advice. It is also used to aid in claim identification if an adjustment is required. Not using a unique number for each drug line billed can lead to credits or adjustments of claims other than those intended. The prescription number is required for drug information submitted on all electronic claim transactions except the Medicare/MO HealthNet crossover claim options on emomed.com.

Can I bill for a non-payable injection, drug or pharmaceutical item under medical supplies?
No. If the injection, drug or other pharmaceutical item does not have an NDC or is not payable under MO HealthNet, it **cannot** be billed under revenue code 270 (medical supplies).

Are hospital's required to keep paper copies of attachments used for physicians' outpatient services, e.g. Second Surgical Opinion Form, Sterilization Consent form, etc.?
Yes. The hospital must maintain a copy of these forms in the patient's permanent file.

Can HCPCS "Q" codes be used to bill for MO HealthNet services?
HCPCS "Q" codes are national codes given by the Center for Medicare Services (CMS) on a temporary basis. In general, "Q" codes are not to be used to bill for MO HealthNet services and are considered non-covered.

Does MO HealthNet have allowable quantities that can be billed for outpatient services?
Yes. Each procedure code has an allowable quantity that can be billed to MO HealthNet without additional documentation. A provider can access the MO HealthNet fee schedules, which include allowable quantities, through the MO HealthNet Division Web site, www.dss.mo.gov/mhd/providers/index.htm.

How is a claim billed when more than the allowable quantity of a procedure was performed?
A provider cannot bill for more than the MO HealthNet allowable quantity on a single line on the claim. The additional quantities have to be billed on subsequent lines and the hospital's notes sent with the claim for manual review and processing. Example - the MO HealthNet allowable for a procedure is two but the hospital wants to bill for five. The hospital would bill one line with the procedure code and a quantity of two, a second

line with the procedure code and a quantity of two, and a third line with the procedure code and a quantity of 1, and the hospital notes submitted with the claim.

What is the proper way to bill for a comprehensive metabolic panel, procedure code 80053?
If only CPT code 80053 was performed, bill the code without any modifiers. Providers should be aware that 80053 might be included in CPT code 80050 (general health panel) if certain other lab services are being billed for the same date of service.

CPT code 80050 includes 80053 in addition to:

> Blood count, complete (CBC), automated and automated differential WBC count (85025) or (85027 and 85004) or,
>
> Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009)
>
> Thyroid stimulating hormone (TSH) (84443)

What is the correct way to bill for outpatient cardiac rehabilitation services?
Providers should bill using the appropriate revenue code, 0943 - cardiac rehabilitation. Do **not** list a CPT procedure code with this revenue code.

Are there special documentation requirements for billing for outpatient missed abortions/miscarriage services?
MO HealthNet does **not** cover elective abortion services.

Any claim with a diagnosis of miscarriage, or missed or spontaneous abortion, diagnosis codes 632, 634.00-634.92, 635.00-635.92, 636-636.92 and 639-639.9, must be submitted on a paper UB-04 claim form with all appropriate documentation attached. The documentation must include the operative report, an ultrasound, the pathology report, the admit and discharge summary, etc. to show that this was not an elective abortion. If no ultrasound was performed, the reason for not performing it must be clearly documented in the patient's medical record.

The above information is required also when submitting a claim with one of the following CPT codes: 59200, 59812, 59821, or 59830.

CPT codes 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, and 59866 also require a completed *Certification of Medical Necessity for Abortion* form in addition to the previously noted documents.